APPENDIX D

Sample SSA Forms

Appendix D contains samples of SSA forms that were mentioned throughout the text of the manual as being necessary or helpful to the process of applying for disability benefits. The following forms are included in this appendix:

- Form SSA–8000—SSI Application
- Form SSA–3368—Disability Report for Adults
- Form SSA–3369—Work History Report
- Form SSA–1696—Appointment of Representative
- Form SSA–561—Request for Reconsideration
- Form SSA–827—Authorization to Disclose Information to SSA
- Form SSA–787—Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits
- Form HA–501—Request for Hearing by Administrative Law Judge
- Form HA–520—Request for Review of Decision/Order of ALJ

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Note: Social Security Administration staff or others who help people apply for SSI will fill out this form for you.

Do not write in this space

I am/We are applying for Supplemental Security Income and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under title XIX of the Social Security Act.

☐ FS-SSA/APP ☐ FS-REFERRED

Filing Date
Month, Day, Year

☐ Actual or ☐ Protective

TYPE OF CLAIM ☐ Individual with Ineligible Spouse ☐ Couple ☐ Individual ☐ Child ☐ Child with Parent(s)

PART I—BASIC ELIGIBILITY—The questions in this section pertain to the period beginning with the first moment of the filing date month through the date this application is signed unless a question specifies a different time period.

1. (a) First Name, Middle Initial, Last Name | Birth *(month, day, year)* | Sex ☐ Male ☐ Female | Social Security Number __ __ __ / __ __ / __ __ __ __

   (b) Did you ever use any other names *(including maiden name)* or other Social Security numbers? → ☐ YES Go to (c) ☐ NO Go to #2

   (c) Other Names and Social Security Numbers Used

2. (a) Are you married? → ☐ YES Go to (b) ☐ NO Go to #4

   (b) Spouse's Name *(First, middle initial, last)* | Birth *(month, day, year)* | Social Security Number __ __ __ / __ __ / __ __ __ __

   (c) Did your spouse ever use any other names *(including maiden name)* or other Social Security Numbers? → ☐ YES Go to (d) ☐ NO Go to (e)

   (d) Other Names *(including maiden name)* and Social Security Numbers Used by Spouse

   (e) Are you and your spouse living together? → ☐ YES If your spouse is not filing go to #3; otherwise go to #4. ☐ NO Go to (f)

   (f) Date you began living apart | Address of spouse or name and address of someone who knows where the spouse is.

   (g) IF YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU SEPARATED SINCE THE FIRST MOMENT OF THE FILING DATE MONTH GO TO #3. IF YOUR SPOUSE IS FILING FOR SUPPLEMENTAL SECURITY INCOME, GO TO #4.

3. (a) Is your spouse the sponsor of an alien for supplemental security income? → ☐ YES Go to (b) ☐ NO Go to #4

   (b) Alien's Name | Alien's Social Security Number __ __ __ / __ __ / __ __ __ __

		You	Your Spouse, if filing
4.	(a) Have you been married before? →	☐ YES Go to (b) ☐ NO Go to #5	☐ YES Go to (b) ☐ NO Go to #5

(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #5.

	FORMER SPOUSE'S NAME (including maiden name)	SOCIAL SECURITY NUMBER (if none or unknown, so indicate)	DATE OF MARRIAGE	DATE MARRIAGE ENDED	HOW MARRIAGE ENDED
You					
Your Spouse					

		You	Your Spouse
5.	(a) Are you blind or disabled? →	☐ YES Go to (b) ☐ NO Go to #6	☐ YES Go to (b) ☐ NO Go to #6

(b) GIVE THE FOLLOWING INFORMATION:	DATE IMPAIRMENT BEGAN	NATURE OF THE IMPAIRMENT
You		
Your Spouse		

		You	Your Spouse, if filing
6.	In what city and State or foreign country were your born? →		
7.	Are you a United States citizen by birth? →	☐ YES Go to #10 ☐ NO Go to #8	☐ YES Go to #11 ☐ NO Go to #8
8.	Are you a naturalized United States citizen? →	☐ YES Go to #11 ☐ NO Go to #9	☐ YES Go to #11 ☐ NO Go to #9
9.	(a) Are you lawfully admitted for permanent residence in the United States? →	☐ YES Go to (b) ☐ NO Go to #10	☐ YES Go to (b) ☐ NO Go to #10
	(b) Give the month, day, and year of lawful admission for permanent residence. If date is within 3 years of the filing date, go to (c); otherwise go to #11 →	DATE	DATE
	(c) Was your entry into the United States sponsored by any person or promoted by an institution or group? →	☐ YES Go to (d) ☐ NO Go to #11	☐ YES Go to (d) ☐ NO Go to #11

(d) Give the following information about the person, institution, or group:

Name	Address	Telephone No. *(Include Area Code)* (__ __ __) -

(e) GO TO #11

		You	Your Spouse, if filing
10.	(a) Is the Immigration and Naturalization Service (INS) aware of your presence in the United States? →	☐ YES Go to (b) ☐ NO Go to #11	☐ YES Go to (b) ☐ NO Go to #11
	(b) Through what date will INS allow you to remain in the United States? (If indefinitely, so indicate) →	DATE *(month, day, year)*	DATE *(month, day, year)*
11.	(a) When did you first make your home in the United States? →	DATE *(month, day, year)*	DATE *(month, day, year)*
	(b) Have you lived outside the United States since then? →	☐ YES Go to (c) ☐ NO Go to #12	☐ YES Go to (c) ☐ NO Go to #12
	(c) Give dates of residence outside the United States. *(Month, day, year)* →	FROM: TO:	FROM: TO:
12.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date? →	☐ YES Go to (b) ☐ NO Go to #13	☐ YES Go to (b) ☐ NO Go to #13
	(b) Give the date *(Month, day, year)* you left the United States and the date you returned to the United States. →	Date Left / Date Returned	Date Left / Date Returned

PART II—LIVING ARRANGEMENTS—The questions in this section pertain to the signature date.

13. Check the applicable block to show where you live now:

☐ House ☐ Apartment ☐ Room (private home) ☐ Room (commercial establishment) ☐ Mobile Home ☐ Foster Home ☐ Transient ☐ Other (Specify) _____

INSTITUTIONS

☐ School ☐ Hospital ☐ Rest or Retirement Home ☐ Nursing Home ☐ Rehabilitation Center ☐ Jail ☐ Other (Specify) _____

IF YOU ARE LIVING IN A FOSTER HOME, AN INSTITUTION, OR ARE A TRANSIENT, EXPLAIN IN REMARKS AND GO TO #21.

14. Do you live alone or with your spouse only? → ☐ YES Go to #16 ☐ NO Go to #15

15. (a) Give the following information about everyone who lives with you (or with you and your spouse):

NAME	RELATIONSHIP TO YOU OR SPOUSE	SEX M	SEX F	DATE OF BIRTH (Month, day, year)	BLIND OR DISABLED YES	BLIND OR DISABLED NO	IF UNDER AGE 22 MARRIED YES	IF UNDER AGE 22 MARRIED NO	IF UNDER AGE 22 STUDENT YES	IF UNDER AGE 22 STUDENT NO

(b) Do all the persons listed in 15(a) receive assistance or income based on need? → ☐ YES Go to (c) ☐ NO Go to (c)

(c) Does anyone listed in 15(a) who is not married and under age 18 OR between ages 18-21, not married, and a student receive income? → ☐ YES Go to (d) ☐ NO Go to #16

(d)

CHILD RECEIVING INCOME	SOURCE & TYPE	MONTHLY AMOUNT
		$
		$
		$

16. (a) Do you (or does anyone who lives with you) own or rent the place where you live? → ☐ YES Go to #17 ☐ NO Go to (b)

(b) Name and address of person who owns or rents the place where you live:

Telephone number, if known *(Include Area Code)* (___ ___ ___) -

(c) GO TO #20

17. (a) Are you (or your living with spouse) buying or do you own the place where you live? → ☐ YES Go to (c) ☐ NO If you are a child living with parent(s) go to (b); otherwise go to #18.

(b) Are your parent(s) buying or do they own the place where you live? → ☐ YES Go to (c) ☐ NO Go to #18

(c) What is the amount and frequency of the mortgage payment? → Amount $ Frequency of Payment

(d) GO TO #20

18.	(a) Do you (or your living with spouse) have rental liability for the place where you live? →	☐ YES Go to (d)	☐ NO If you are a child living with parent(s) go to (b); otherwise go to (c).
	(b) Do your parent(s) have rental liability? →	☐ YES Go to (d)	☐ NO Go to (c)
	(c) Does anyone who lives with you have rental liability for the place where you live? →	☐ YES Give name of person with rental liability in Remarks and go to #19	☐ NO Give name of person with home ownership in Remarks and go to #20.
	(d) What is the amount and frequency of the rent payment? →	Amount $	Frequency of payment
19.	(a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? →	☐ YES Go to (b)	☐ NO Go to #20
	(b) Name of person related to landlord or landlord's spouse:	Relationship	Name and address of landlord (include telephone number and area code, if known):

20. (a) Does anyone who does NOT live with you provide your household with all or part of the food and shelter (including payment of the bills for food, rent or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewerage) or give the household money for these items? → ☐ YES Go to (b) ☐ NO Go to (c)

(b) ITEM	CONTRIBUTOR'S NAME AND ADDRESS (TELEPHONE NUMBER AND AREA CODE, IF KNOWN)	MONTHLY AMOUNT	MONTHS RECEIVED
		$	
		$	
		$	
		$	

(c) GO TO (d) IF YOU (OR YOUR LIVING WITH SPOUSE) OWN OR RENT AND LIVE WITH OTHERS (OTHER THAN SPOUSE ONLY) BUT YOU DO NOT LIVE IN A PUBLIC ASSISTANCE HOUSEHOLD; OTHERWISE, GO TO #21.

	(d) Does anyone living with you give you (or your living with spouse) money for or help pay for all or part of your food, rent or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewer bills? →	☐ YES Go to #21	☐ NO Go to #21
21.	(a) Has the information given in items #13 through #20 been the same since the first moment of the filing date month? →	☐ YES Go to (b)	☐ NO Explain in Remarks and go to (b).
	(b) Do you expect this information to change? →	☐ YES Explain in Remarks and go to #22.	☐ NO Go to #22

PART III—RESOURCES—The questions in this section pertain to the first moment of the filing date month.

22.	(a) Do you own or does your name appear on the title of any vehicles; e.g., cars, trucks, boats, motorcycles, etc.? →			You ☐ YES Go to (b) ☐ NO Go to #23		Your Spouse ☐ YES Go to (b) ☐ NO Go to #23	
	(b) OWNER'S NAME	DESCRIPTION (YEAR, MAKE & MODEL)	USED FOR	EQUIPPED FOR HANDICAPPED? YES	EQUIPPED FOR HANDICAPPED? NO	CURRENT MARKET VALUE	AMOUNT OWED
						$	$
						$	$
						$	$

23. (a) Do you own or are you buying any life insurance policies? →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #24	☐ YES Go to (b) ☐ NO Go to #24

(b) Give the following information on each policy:

OWNER'S NAME	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY
Policy (#1)		
Policy (#2)		
Policy (#3)		

POLICY NUMBER	FACE VALUE	CASH SURRENDER VALUE	DATE PURCHASED	LOANS AGAINST	
				YES	NO
Policy (#1)	$	$		$	
Policy (#2)	$	$		$	
Policy (#3)	$	$		$	

24. (a) Do you (either alone or jointly with any other person) own any:

	You		Your Spouse	
	YES	NO	YES	NO
Life estates or ownership interest in an unprobated estate? →				
Household or personal items worth more than $500 each? →				

(b) Give the following information for any "Yes" answer in 24(a); otherwise go to #25

OWNER'S NAME	NAME OF ITEM	VALUE	AMOUNT OWED ON ITEM	WHERE APPROPRIATE, GIVE NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION
		$	$	
		$	$	

25. (a) Do you own or does your name appear (either alone or with any other person's name) on any of the following items?

	You		Your Spouse	
	YES	NO	YES	NO
Cash at home, with you, or anywhere else →				
Checking Accounts →				
Savings Accounts →				
Credit Union Accounts →				
Christmas Club Accounts →				
Certificates of Deposit →				
Notes →				
Stocks or Mutual Funds →				
Bonds →				
Other items that can be turned into cash →				

(b) Give the following information for any "Yes" answer in 25(a); otherwise go to #26

OWNER'S NAME	NAME OF ITEM	VALUE	NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION IF APPROPRIATE	IDENTIFYING NUMBER
		$		
		$		
		$		
		$		

26.	(a) Do you have any land, houses, buildings, real property, property in foreign countries, equipment, business, mineral rights or other money or property of any kind (including belongings held in safe deposit boxes) that have not been shown elsewhere on the application? (Include assets set aside for an emergency or to provide for your heirs.) →	You		Your Spouse	
		☐ YES Go to (b)	☐ NO Go to #27	☐ YES Go to (b)	☐ NO Go to #27

(b) Give the following information:

DESCRIPTION OF PROPERTY (If real property, include type and size of structure, acreage or lot size, location.)	HOW IS IT USED? (If not used now, when was it last used and what is next planned use.)
Item 1	Item 1
Item 2	Item 2

OWNER'S NAME	ESTIMATED CURRENT MARKET VALUE	TAX ASSESSED VALUE	AMOUNT OF MORTGAGE PAYMENT	AMOUNT OWED ON ITEM
Item 1	$	$	$	$
Item 2	$	$	$	$

27.	(a) Have you sold, transferred title, disposed of or given away any money or other property, including property or money in foreign countries, since the first day of the month in which you filed your application or within the 30 months prior to the filing date month?	You		Your Spouse, if filing	
		☐ YES Go to (b)	☐ NO Go to #28	☐ YES Go to (b)	☐ NO Go to #28

(b) Give the following information:

OWNER'S NAME	DATE OF DISPOSAL	DESCRIPTION OF PROPERTY
Item 1		
Item 2		

IF THE DATE OF DISPOSAL IS BEFORE 7/1/88 AND LESS THAN 24 MONTHS PRIOR TO THE MONTH OF FILING OR IF THE DATE OF DISPOSAL IS AFTER 6/30/88, GO TO 27(c); OTHERWISE GO TO #28.

(c) Give the following about the information in 27(b):

NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	SOLD ON OPEN MARKET	
		YES	NO
Item 1			
Item 2			

VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT	SALES PRICE OR OTHER AGREEMENT	ARE ADDITIONAL CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN	DO YOU STILL OWN PART OF THE PROPERTY	
			YES	NO
Item 1 $				
Item 2 $				

28. (a) Have you acquired any resource since the first moment of the filing date month? →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to (c)	☐ YES Go to (b) ☐ NO Go to (c)

(b) Explain any "Yes" answer given in 28(a)

You	Your Spouse

(c) Has there been any increase or decrease in the value of your resources since the first moment of the filing date month? →

You	Your Spouse
☐ YES Go to (d) ☐ NO Go to #29	☐ YES Go to (d) ☐ NO Go to #29

(d) Explain any "Yes" answer given in 28(c)

You	Your Spouse

29. (a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any assets mentioned in items #22 through #26 and item #28. →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #30	☐ YES Go to (b) ☐ NO Go to #30

(b) DESCRIPTION (Where appropriate, give name and address of organization and account/policy number)	AMOUNT	WHEN SET ASIDE (Month, Day, Year)	OWNER'S NAME
Item 1	$		
Item 2	$		

	FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?
Item 1		☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain in (c)
Item 2		☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain in (c)

(c) Explanation:

Item 1	
Item 2	

30. (a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums or other repositories for burial or any headstones or markers? →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #31	☐ YES Go to (b) ☐ NO Go to #31

(b) OWNER'S NAME	DESCRIPTION	FOR WHOSE BURIAL	RELATIONSHIP TO YOU OR SPOUSE	CURRENT MARKET VALUE (if applicable)
				$
				$

PART IV—INCOME—The questions in this section specify time period.

31. (a) Since the first moment of the filing date month, have you received or do you expect to receive income in the next 14 months from any of the following sources?	YOU		YOUR SPOUSE	
	YES	NO	YES	NO
FEDERAL BENEFITS: Social Security				
Railroad Retirement				
Veterans Administration (Based on need/not based on need)				
Office of Personnel Management (Civil Service)				
Military Pension, Special Pay, or Allowance				
Black Lung				
Bureau of Indian Affairs				
Earned Income Tax Credits				
STATE/LOCAL BENEFITS: Unemployment Compensation				
Workers' Compensation				
State Disability				
State or Local Pension				
Aid to Families with Dependent Children				
State or Local Assistance Based on Need				
PRIVATE BENEFITS: Employer or Union Pension				
Insurance or Annuity Payments				
MISCELLANEOUS: Interest (bank accounts, stocks, CD's, etc.)				
Rental/Lease Income				
Dividends/Royalties				
Alimony				
Child Support				
OTHER INCOME NOT PREVIOUSLY MENTIONED				

(b) Give the following information for any "Yes" answer in 31(a); otherwise go to #32.

PERSON RECEIVING	TYPE OF INCOME	AMOUNT	FREQUENCY	DATES EXPECTED OR RECEIVED	SOURCE (Name/Address of Person, Bank, Company, or Organization)	IDENTIFYING NUMBER
You		$		From: / To:		
You		$		From: / To:		
You		$		From: / To:		
Your Spouse		$		From: / To:		
Your Spouse		$		From: / To:		
Your Spouse		$		From: / To:		

		You	Your Spouse
32.	Since the first moment of the filing date month, have you received or do you expect to receive any clothing, meals, or other gifts which are not cash? →	☐ YES Explain in Remarks and go to #33 ☐ NO Go to #33	☐ YES Explain in Remarks and go to #33 ☐ NO Go to #33
33.	(a) Have you received wages since the first moment of the filing date month through the current month? →	☐ YES Go to (b) ☐ NO Go to (d)	☐ YES Go to (b) ☐ NO Go to (d)

(b) Name and Address of Employer *(include telephone number and area code, if known)*

You	Your Spouse

(c) Total wages received (before any deductions) for each month:

You	Month(s)							
	Amounts							
Your Spouse	Month(s)							
	Amounts							

	You	Your Spouse
(d) Do you expect to receive any wages in the next 14 months? →	☐ YES Go to (e) ☐ NO Go to #34	☐ YES Go to (e) ☐ NO Go to #34

(e) Name and address of employer if different from 33(b) *(include telephone number and area code, if known)*

You	Your Spouse

(f) Give the following information:

	RATE OF PAY	AMOUNT WORKED PER PAY PERIOD	HOW OFTEN PAID	PAY DAY OR DATE PAID	DATE LAST PAID *(Month, day, year)*
You	$ per				
Your Spouse	$ per				

	You	Your Spouse
(g) Do you expect any change in wage information provided in 33(f)? →	☐ YES Go to (h) ☐ NO Go to #34	☐ YES Go to (h) ☐ NO Go to #34

(h) Explain change:

You	Your Spouse

		You	Your Spouse
34.	(a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?	☐ YES Go to (b) ☐ NO Go to #35	☐ YES Go to (b) ☐ NO Go to #35

(b) Give the following information:

	TYPE OF BUSINESS	LAST YEAR'S: GROSS INCOME	LAST YEAR'S: NET INCOME	LAST YEAR'S: NET LOSS	THIS YEAR'S: GROSS INCOME	THIS YEAR'S: NET INCOME	THIS YEAR'S: NET LOSS	DATES OF SELF-EMPLOYMENT
You		$	$	$	$	$	$	
		$	$	$	$	$	$	
Your Spouse		$	$	$	$	$	$	
		$	$	$	$	$	$	

IF YOU OR YOUR SPOUSE ARE DISABLED AND RECEIVE WAGES OR EXPECT TO RECEIVE WAGES OR ARE SELF-EMPLOYED OR EXPECT TO BE SELF-EMPLOYED, ANSWER #35: OTHERWISE, GO TO #36.

35.		You	Your Spouse
	Do you have any special expenses related to your illness or injury that you paid which are necessary for you to work? →	☐ YES Describe in Remarks and go to #36 ☐ NO Go to #36	☐ YES Describe in Remarks and go to #36 ☐ NO Go to #36

IF YOU ARE FILING AS A CHILD, AND YOU ARE EMPLOYED OR AGE 18-22 (WHETHER EMPLOYED OR NOT), GO TO #36; OTHERWISE, GO TO #37.

36.			
	(a) Have you attended school regularly since the filing date month? →	☐ YES Go to (d)	☐ NO Go to (b)
	(b) Have you been out of school for more than 4 calendar months? →	☐ YES Go to (c)	☐ NO Go to (c)
	(c) Do you plan to attend school regularly during the next 4 months? →	☐ YES Explain absence in Remarks and go to (d)	☐ NO Go to #37

(d) Give the following information:

NAME AND ADDRESS OF SCHOOL	NAME OF PERSON AT SCHOOL WE MAY CONTACT	DATES OF ATTENDANCE	COURSE OF STUDY
	NAME PHONE (Area Code) ( ) -	FROM / TO HOURS ATTENDING OR PLANNING TO ATTEND:	

PART V—POTENTIAL ELIGIBILITY FOR OTHER BENEFITS/FOOD STAMPS/MEDICAL ASSISTANCE

37. (a) Have you or a former spouse (or if you are filing as a child, have you or your parents) ever:	YOU		YOUR SPOUSE	
	YES	NO	YES	NO
Worked for a railroad?				
Been in military service?				
Worked for the Federal government?				
Worked for a State or local government?				
Worked for an employer or belonged to a union with a pension plan?				
Done work that was covered under the Social Security system or pension plan of a country other than the United States?				

(b) Explain and include dates (if appropriate) for any "Yes" answer given in 37(a); otherwise go to #38.

YOU	YOUR SPOUSE

		You	Your Spouse, if filing
38.	(a) Are you currently receiving food stamps or has a food stamp application been filed for you within the past 60 days on which there has not been a decision? →	☐ YES Go to #39 ☐ NO Go to (b)	☐ YES Go to #39 ☐ NO Go to (b)
	(b) Do you wish to apply for food stamps? →	☐ YES ☐ NO	☐ YES ☐ NO

39. **Where this application is an application for Title XIX under the Social Security Act, I/we understand that if I/we refuse to assign my/our rights to medical support and payments for medical care from any individual or private, group, or government health insurance, or refuse to cooperate in giving information regarding any health insurance I/we may have, that the Social Security Administration cannot determine whether I am/we are eligible for Medicaid and that I/we must then apply for Medicaid at the Medicaid agency. I/we also understand that as a condition to become eligible for Medicaid, I/we must cooperate with the Medicaid agency in establishing paternity and in obtaining medical support and payments from third party payers.**

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, GO TO 39(b).

		You	Your Spouse, if filing
	(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency? →	☐ YES Go to (b) ☐ NO Go to #40	☐ YES Go to (b) ☐ NO Go to #40
	(b) Do you, your spouse, parent or step-parent have any private, group, or government health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid) →	☐ YES ☐ NO	☐ YES ☐ NO
	(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month? →	☐ YES ☐ NO	☐ YES ☐ NO

PART VI—MISCELLANEOUS

ANSWER #40 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE, GO TO #41.

40.	(a) Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number __ __ __/__ __/__ __ __ __		
	(b) Do you wish to be selected as the claimant's representative payee? →	☐ YES	If you are applying on behalf of a child go to (c); otherwise go to #41.	☐ NO	Explain in Remarks and go to #41.
	(c) Are you the natural or adoptive parent with custody? →	☐ YES	Go to (d)	☐ NO	Go to (d)
	(d) Have you ever been convicted of a felony? →	☐ YES	Explain in Remarks and go to (e)	☐ NO	Go to (e)
	(e) Are you serving, or have you ever served, as representative payee for anyone receiving a Social Security or Supplemental Security Income benefit? →	☐ YES	Enter SSN's in Remarks and go to (f)	☐ NO	Go to (f)
	(f) Does the claimant have a legal representative or a legal guardian appointed by a court? →	☐ YES	If you are NOT the legal rep/guardian, go to (g); otherwise go to (h).	☐ NO	Go to #41

(g) Give the following information about the legal representative or legal guardian:

Name	Address	Telephone Number *(Include area code, if known)*
		(___) -

(h) Explain what led the court to appoint a legal representative or a legal guardian.

PART VII—REMARKS—(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

IMPORTANT INFORMATION—PLEASE READ CAREFULLY

- Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- If you are disabled or blind, you must accept any appropriate vocational rehabilitation services offered to you by the State agency to which we refer you.

PART VIII—SIGNATURES

I/We understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I/we know it.

41. Your Signature *(First name, middle initial, last name) (Write in ink)*
SIGN HERE ▶
Date *(Month, day, year)*
Telephone number(s) at which you may be contacted during the day
(___ ___ ___) – AREA CODE

42. Spouse's Signature *(First name, middle initial, last name) (Write in ink)*
(Sign only if applying for payments.)
SIGN HERE ▶

43. **FOR OFFICIAL USE ONLY**
DIRECT DEPOSIT PAYMENT ADDRESS *(FINANCIAL INSTITUTION)*
Routing Transit Number | C/S | Depositor Account Number
☐ No Account
☐ Direct Deposit Refused

44. Applicant's Mailing Address *(Number and Street, Apt. No., P.O. Box or Rural Route)*
City and State | ZIP Code | Enter name of county *(if any)* in which you live

45. Claimant's Residence Address *(If different from applicant's mailing address)*
City and State | ZIP Code | Enter name of county *(if any)* in which the claimant lives

WITNESSES

46. Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	*Address (Number and Street, City, State, and ZIP Code)*

*U.S. Government Printing Office: 1999 — 454-992/00011

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

NAME	SOCIAL SECURITY NUMBER — — — / — — / — — — —	DATE
NAME	SOCIAL SECURITY NUMBER — — — / — — / — — — —	

Telephone Number *(include area code)* to call if you have a question or something to report.	Social Security Office you may come in person or mail your request to:
(_ _ _) -	

Your application for Supplemental Security Income will be processed as quickly as possible. If you have trouble getting any information or records we have asked for, please contact us and we will help you.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed. If you do not get a check or a notice of determination within that time, please get in touch with us in person, by mail, or by calling the telephone number shown above.

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on your application form under Section 1631 (e) of the Social Security Act, as amended (42 U.S.C. 1383(e)). Your response to this request is voluntary; however, as explained below, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure payments not authorized by the Social Security Act.

The information on your application is needed to enable Social Security to determine if you are eligible for Supplemental Security Income payments. Failure to provide all or part of the information could prevent an accurate and timely decision on your claim, and could result in the loss of some payments. Although the information you furnish on the application is rarely used for any other purpose than stated in the foregoing, there is a possibility that information may be disclosed to another person or to another governmental agency as follows: (1) to enable a third party or an agency to assist Social Security in establishing rights to Supplemental Security Income payments, and (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Department of Veterans Affairs).

Computer Matching We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

Time It Takes To Complete This Form: We estimate that it will take you about 34 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.**

REPORTING RESPONSIBILITIES

The amount of a Supplemental Security Income check is based on the information told to us. You must tell Social Security every time there is a change—while we process your application AND if you start receiving Supplemental Security Income.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible husband/wife or a child who lives with you, or your sponsor or sponsor's spouse if you are an alien. You must also report changes in things of value that these people own.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as $25, $50, or $100 out of future checks.

HOW TO REPORT **You can make your reports by telephone at the telephone number shown above or you may report in person or by mail at the address shown above. See reverse side of this page for "Changes to Report."**

CHANGES TO REPORT

☑ **WHERE YOU LIVE — You must report to Social Security if:**

- You move.
- You (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.
- You leave the United States for 30 days or more.
- You are released from a hospital, nursing home, etc.
- You are no longer a legal resident of the United States.

☑ **HOW YOU LIVE — You must report to Social Security if:**

- Someone moves into or out of your household.
- The amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your marital status changes:
  - You get married, separated, divorced, or your marriage is annulled.
  - You separate from your spouse or start living together again after a separation.
  - You begin living with someone as husband and wife.

☑ **INCOME — You must report to Social Security if:**

- The amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down or you start to receive money (or checks or any other type of payment).
- You start work or stop work.
- Your earnings go up or down.

☑ **HELP YOU GET FROM OTHERS — You must report to Social Security if:**

- The amount of help (money, food, clothing, or payment of household expenses) you receive goes up or down.
- Someone stops helping you.
- Someone starts helping you.

☑ **THINGS OF VALUE THAT YOU OWN — You must report to Social Security if:**

- The value of your resources goes over $2,000 when you add them all together ($3,000 if you are married and live with your spouse).
- You sell or give any things of value away.
- You buy or are given anything of value.

☐ **YOU ARE BLIND OR DISABLED — You must report to Social Security if:**

- Your condition improves or your doctor says you can return to work.
- You go to work.
- You stop going to or refuse any vocational rehabilitation services.
- You stop going to or refuse treatment for drug addiction or alcoholism.

☐ **YOU ARE UNMARRIED AND UNDER AGE 22 — A report to Social Security must be made if:**

- If you are under age 18 and live with your parent(s), ask your parent(s) to report if they have a change in income, a change in their marriage, a change in the value of anything they own, or either has a change in residence.
- You start or stop school.
- You get married.

☐ **YOUR IMMIGRATION AND NATURALIZATION SERVICE (INS) STATUS CHANGES—You must report any change to Social Security.**

☐ **YOU ARE SELECTED AS A REPRESENTATIVE PAYEE — You must report to Social Security if:**

- The person for whom you receive SSI checks has any of the changes listed above. (You may be held liable if you do not report changes that could affect the SSI recipient's payment amount, and he/she is overpaid.)
- You will no longer be able or no longer wish to act as that person's representative payee.

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at http://www.socialsecurity.gov/disability/3368/index.htm.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this info
book, or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ *Area Code* _____ *Number* ☐ Your Number ☐ Message Number ☐ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ *City* _____ *State* _____ *ZIP* DAYTIME PHONE _____ *Area Code* _____ *Number*

E. What is your **height** without shoes? _____ *feet* _____ *inches*

F. What is your **weight** without shoes? _____ *pounds*

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak and understand English**? ☐ YES ☐ NO If "**NO**," what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO *(If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)*

NAME _____ **RELATIONSHIP** _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ *City* _____ *State* _____ *ZIP* **DAYTIME PHONE** _____ *Area Code* _____ *Number*

I. Can you **read and understand English**? ☐ YES ☐ NO

J. Can you **write more than your name in English**? ☐ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you**? | *Month* | *Day* | *Year* |

E. When did you become **unable to work** because of your illnesses, injuries or conditions? | *Month* | *Day* | *Year* |

F. Have you **ever worked**? ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did **you stop working**? | *Month* | *Day* | *Year* |

J. Why did you **stop working**? _____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE *(Example, Cook)*	TYPE OF BUSINESS *(Example, Restaurant)*	DATES WORKED *(month & year)*		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY *(Per hour, day, week,month or year)*	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

H. Check weight **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (If NO, go to J.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. _____

_____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE _____ *Area Code* _____ *Phone Number*		**PATIENT ID #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS _____			
WHAT **TREATMENT** WAS RECEIVED? _____			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE _____ *Area Code* _____ *Phone Number*		**PATIENT ID #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS _____			
WHAT **TREATMENT** WAS RECEIVED? _____			

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE *Area Code* *Phone Number*		**PATIENT ID #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE *Area Code* *Phone Number*			NEXT APPOINTMENT
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: _____

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____

City *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____

City *State* *Zip*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 9 - REMARKS

Name of person completing this form (*Please Print)*	**Date Form Completed** *(Month, day, year)*
Address *(Number and street)*	**e-mail address** *(optional)*
City **State**	**Zip Code**

WORK HISTORY REPORT-Form SSA-3369-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can. Then call the phone number provided on the letter sent with the form or the phone number of the person who asked you to complete the form for help to finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Print or type.
- A reference to "you," "your," or "the Disabled Person," or "claimant" means the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- **ANSWER ALL OF THE QUESTIONS FOR EACH JOB YOU DESCRIBE.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. The information tells us about the kinds of work you did, including the types of skills you needed and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different jobs you did in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. There is a separate page to describe each different job.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 8

Privacy Act and Paperwork Reduction Act Statements

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 1 hour to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to*: *SSA*, *1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0578

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. Name (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER

– –

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

( ) –
Area Code *Phone Number*

☐ Your Number ☐ Message Number ☐ None

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

Job Title	Type of Business	Dates Worked *(Month & Year)*	
		From	To
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1		
Rate of Pay $ _____ Per *(Check One)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2	

Rate of Pay $_____	Per *(Check One)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day ____	Days per week ____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3

Rate of Pay	Per *(Check One)*	Hours per day	Days per week
$_____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	_____	_____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4		
Rate of Pay $_____ Per *(Check One)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay	Per *(Check One)*	Hours per day	Days per week
$_____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	_____	_____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6		
Rate of Pay Per *(Check One)* $_____ ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

Describe this job. What did you do all day? *(If you need more space, write in the"Remarks" section.)*

_____

_____

_____

In this job, did you:

Use machines, tools or equipment?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In **this job**, how many total hours each day did you:

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab or grasp big objects? _____
Reach? _____
Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

SECTION 3 - REMARKS

Use this section to add any information you did not have space for in other parts of the form. Show the page number of the part you are continuing.

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

Name of person completing this form *(Please print)*	**Date** *(Month, day, year)*	
Address *(Number and Street)*	**Email address** *(optional)*	
City	**State**	**Zip Code** –

Social Security Administration

Form Approved
OMB No. 0960-0527

Please read the back of the last copy before you complete this form.

Name (Claimant) **(Print or Type)**	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, _____ ,
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I appoint, or I now have, more than one representative. My main representative is _____ .
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part II **ACCEPTANCE OF APPOINTMENT**

I, _____ , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney who is eligible to receive direct fee payment.

☐ I am not an attorney and I am ineligible to receive direct fee payment.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part III (Optional) **WAIVER OF FEE**

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional) **WAIVER OF DIRECT PAYMENT**

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney or Eligible Non-Attorney (for Direct Payment) Representative)	Date

INFORMATION FOR CLAIMANTS

What a Representative May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- o get information from your claim(s) file;
- o give us evidence or information to support your claim;
- o come with you, or for you, to any interview, conference, or hearing you have with us;
- o request a reconsideration, hearing, or Appeals Council review; and
- o help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you tell us that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

o Filing a Fee Petition

Your representative may ask for approval of a fee by giving us a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time he or she spent on each service provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

What Your Representative(s) May Charge, continued

o Filing A Fee Agreement

If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $5,300 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we approve, except for:

- o any fee a Federal court allows for your representative's services before it; and
- o out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. If an attorney or a non-attorney who is eligible to receive direct fee payment represents you, and if your retirement, survivors, disability insurance, and/or supplemental security income claim(s) results in past-due benefits, we usually withhold 25 percent of your past-due benefits to pay toward the fee for you.

You must pay your representative directly:

- o the rest of the fee you owe
  - if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your representative for you.
- o all of the fee you owe
  - if we did not withhold past-due benefits, for example, because your representative waived direct payment, or you discharged the representative, or the representative withdrew from representing you before we issued a favorable decision; or if we withheld, but later paid you the money because your representative did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
SOCIAL SECURITY CLAIM NUMBER	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER
SPOUSE'S NAME *(Complete ONLY in SSI cases)*	SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)*

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision) instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER *(Include area code)*		DATE	TELEPHONE NUMBER *(Include area code)*		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO

2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*

☐ ODO, BALTIMORE

☐ PROGRAM SERVICE CENTER

☐ OIO, BALTIMORE

☐ OEO, BALTIMORE

☐ DISTRICT OFFICE RECONSIDERATION

☐ CENTRAL PROCESSING SITE (SVB)

NOTE: Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

There are three different ways to appeal. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.

You can pick this kind of appeal in all cases.

2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out the front of this form. We'll help you fill it out.

There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213.** *Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.*

Form **SSA-561-U2** (7-2003) EF (3-2005)
Destroy Prior Editions

Social Security Forms

Form SSA-561-U2

REQUEST FOR RECONSIDERATION

FIRST APPEAL: This request is made by completing the SSA-561-U2, Request for Reconsideration. If you are uncertain whether this is the appropriate request to file, the letter you received explains our determination and contains a paragraph specifically mentioning your right to file a request for reconsideration.

OVERPAYMENT: If you have been overpaid, and do not agree with the fact or the amount of the overpayment, you should complete the SSA-561-U2, Request for Reconsideration.

If you feel you are overpaid but you should not have to pay back the overpayment you should complete a form SSA-632-BK, Request for Waiver of Recovery of an Overpayment.

If you both disagree with the fact you are overpaid (or the amount) and feel, if it is determined you are overpaid, you should not have to refund the overpayment, you can file both requests, SSA-561-U2 and SSA-632-BK.

EVIDENCE: You should present any evidence you have that shows the original determination was incorrect. In the case of a denied claim for a disability benefit you must complete and sign additional forms. These forms are the SSA-3441-F6 , Reconsideration Disability Report, and SSA-827 , Authorization to Disclose Information to SSA.

If you have further questions about filing for reconsideration call 1-800-772-1213, or contact your local SSA office. If you contact us be sure to have available any letters to which you may be referring.

HOW TO COMPLETE THE SSA-561-U2,
REQUEST FOR RECONSIDERATION

1. NAME OF CLAIMANT: Name of the individual on whose behalf this reconsideration is being filed.

2. NAME OF WAGE EARNER OR SELF EMPLOYED INDIVIDUAL: If you receive social security benefits from another person having worked, enter that person’s name.

3. SOCIAL SECURITY CLAIM NUMBER: This is the Social Security number of the wage earner as shown in number 2 above with a suffix after it (ie, HA, B2,

C1, D, etc.) It is placed on all correspondence you receive from SSA.

4. SUPPLEMENTAL SECURITY INCOME (SSI) CLAIM NUMBER: For SSI claimants. This will normally be the claimant's Social Security number.

5. SPOUSES NAME: Complete this only if you are filing a reconsideration on an SSI claim.

6. SPOUSES SOCIAL SECURITY NUMBER: Complete this only if you are filing an SSI claim.

7. CLAIM FOR: State the type of claim/decision on which you wish reconsideration (retirement, SSI disability, Social Security disability, SSI overpayment, etc).

8. "I DO NOT AGREE... MY REASONS ARE:": Briefly state the determination with which you disagree and why you disagree with that determination- you can add to this statement by using the back of the form or a continuation sheet.

9. In SSI cases you can request different ways to handle the appeal. Read the attachments to the SSA-561-U2 regarding these methods and mark your preference.

10A. The legal representative signs on the left side and/or the claimant signs on the right side. Addresses should be annotated accordingly. If you wish to have a legal representative (attorney, etc) you need to contact SSA to request a form SSA-1696. You do not have to delay filing your request for this form, however we cannot discuss your case with your legal representative until this form has been filed.

10B. Make sure to provide your current day-time phone number.

YOU DO NOT NEED TO COMPLETE ANYTHING ELSE ON THIS FORM. OUR REPRESENTATIVE WILL COMPLETE THE REST OF THE FORM WHEN WE RECEIVE IT. YOU WILL BE SENT A PHOTOCOPY FOR YOUR RECORDS.

Social Security Appeals Process

Forms:

- Reconsideration Disability Report, SSA-3441-F6
- Authorization to Disclose Information to the Social Security Administration, SSA-827
- Request for Waiver of Recovery of an Overpayment, SSA-632-BK

HOW TO OBTAIN THE SSA-561-U2

Below you will find the FORM SSA-561-U2 REQUEST FOR RECONSIDERATION in Portable Document Format (PDF). The PDF permits you to print out a duplicate of the original form using ANY graphics printer. The PDF was developed by Adobe Systems, Inc. and allows the reader to print a publication close in appearance to the original printed version, preserving typography, columns, charts, tables and graphics.

To read and print a PDF publication, you must have the Adobe Acrobat Reader software installed on your PC. Adobe Systems, Inc. permits the Social Security Administration and other organizations to offer this software to the public free of charge. You can download the Adobe Acrobat Reader version suitable for your system by clicking on this button .

After you download the Adobe Acrobat Reader, come back to this page and download the PDF version of the SSA-561-U2 below. *Remember to enable the "Load to Disk" capability of your WWW browser prior to downloading the SSA-561-U2 in either PDF format*. PDF files are printer independent and should print easily on any graphics printer (i.e., laser, inkjet, dot-matrix).

HOW TO FORWARD THE SSA-561-U2 TO SSA

Print the PDF SSA-561-U2 form on 8 1/2 x 11 inch paper, complete and sign form, fold in thirds, insert it in a standard size number 10 business envelope (4 1/8 x 9 1/2) and mail to your closest Social Security office. If you are not sure where your local office is located, try our Social Security Office Locator service or call 1-800-772-1213.

SSA-561-U2 in

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last)*

SSN _ _ | Birthday *(mm/dd/yy)*

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN _ _

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including,*** **and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code) ( ) –	City	State	ZIP –

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Online

Disability Home

Disability Programs

Authorization to Release Medical and Other Information

How Do I Get the Forms?

If you call us to apply, we will mail you the forms.
OR you may visit your nearest Social Security Office
OR you can print the forms (see Printing Authorization Forms). We need your **dated original signature** on all forms.

IMPORTANT: When you contact us to apply, we will tell you where to send or bring the forms.

No. The form and instructions on this site apply to children and adults

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I'm Applying for A Child. Are the Forms Different?

More About Benefits for Children with Disabilities

If you need help with any Social Security forms, you can call us toll free at 1-800-772-1213 or visit your local Social Security office. We'll be glad to help you.

More information about how to contact us.

Instructions: FORM SSA-827

We need your written authorization to help get the information required to process your claim. The SSA-827 is arranged in several sections that provide the most important items legally required for an authorization.

Important Note:

This form is NOT an application for disability benefits. You must contact SSA to apply. These forms are used in addition to your application to collect information about you so we can decide if you meet Social Security's definition of disability.

What is this Form Used For?

The Authorization to Release Information will be used to request medical records from your health care providers and other people who can provide us with information about your disability. We will need a separate form for each place or person that will provide information.

- This form is used to contact your doctors and other health care providers, and others who will give us information about you to help us decide your application for disability benefits.
- When you apply, we will give you the forms. But for convenience, they are available on the Internet.

The **"OF WHAT"** section has everything needed for the release of what is considered especially sensitive information, about mental impairment(s); substance abuse; sickle cell anemia; HIV/AIDS or tests for HIV or sexually transmitted diseases; and gene-related impairments (including genetic test results). This specific authorization is routinely included on the form to speed processing the claim and does not mean that we think you may have any of these conditions. Item number 3, about educational tests, usually only applies when the subject of the disclosure is a child. In order to avoid delays caused by getting more forms signed in the future, we also ask you to authorize disclosure of information that may result from treatment after you sign the form. If you have questions regarding this section, or any other aspect of the SSA-827 call 1-800-772-1213 or contact your local Social Security office.

The **"FROM WHOM"** section covers all the sources we may need to contact to help get information about your claim. We need an **original signed, dated, and witnessed** (not photocopied) form for **EACH** medical or other source that you listed on your disability report form(s):
(SSA-454, SSA-782, SSA-3368, SSA-3441, SSA-3820, SSA-3881, HA-4486).
Please include at least **2 extra original, signed, dated, and witnessed** forms. These forms may be used to get information from sources that you had forgotten about. (For example, if you have 5 sources, we will need at least 7 SSA-827s). Please do not send us copies of a signed form.

The other sections of the form are fairly self-explanatory.

How to Complete the Form?

1. Read the entire form, front and back. The information on the back explains some more about how the form will be used and explains the possible consequences of not signing the form. Additional instructions are also on the form. If you have any questions, please contact us.
2. Be sure the name of the person whose records must be disclosed (the applicant or beneficiary) is written in the upper right corner of the form, with their own Social Security Number. SSA will fill in the rest of that block if needed.
3. Do not fill in the large empty box in the middle of the form; SSA will use this space to help the source identify the information we need.
4. Do not put a check in the empty block under "PURPOSE" unless SSA specifically asks you to.
5. INDIVIDUAL SIGN" - Sign each form in this block.
    - An adult should sign his/her own form.
    - An individual can sign with an "X" if necessary• If an individual has been declared legally incompetent, his/her legal guardian or other legally recognized representative should sign the form.
    - If the individual whose information is going to be disclosed is not the one signing the form, be sure to check the box to the right that shows

that person's authority to sign (parent, guardian, etc.) and then give proof of that legal relationship to SSA. If the subject of disclosure is a minor, then a custodial parent, guardian or other legally recognized representative should sign the form.
- If the subject of the disclosure is age 12 or older but still considered to be a minor under State law, he or she should sign the form and the parent, guardian or other legally recognized representative should sign in the "Parent/guardian sign" area to the right.

6. ALWAYS enter the DATE the form is signed.
7. Enter the address and daytime phone number of the individual signing the form.
8. "WITNESS SIGN" - The signature of the individual signing the forms must be witnessed by at least one other individual. Many sources will not honor our request unless it is witnessed.
   - The witness can be any competent adult (spouse, social worker, Social Security employee, etc.).
   - The witness should sign and provide his or her address information in case the source wants to confirm the signature.
   - A second witness is usually only required if the subject of the disclosure signs with an "X."

Printing Authorization Forms?

SSA offers forms in Portable Document Format (PDF). To read and print a PDF publication, you must have the Adobe Acrobat Reader ® software installed on your computer. You can download the Adobe Acrobat Reader for no charge.
Authorization to Release Information Form (SSA-827)

What to do with the Form?

Mail it to the Social Security office that is servicing your claim or bring it with you if you are going into that office. If you have not yet filed a claim, please contact us about filing an application for disability benefits.
CONTACT SOCIAL SECURITY NOW.

Other SSA Forms

Disability Report Form Guide

Learn More About Disability Benefits and How We Decide If You Are Disabled

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No.0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

▪

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER __ __ __ / __ __ / __ __ __ __	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient _____ .

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print.)*	TITLE
ADDRESS *(Number and street, City, State, and ZIP Code)*	TELEPHONE NUMBER *(Include Area Code)* ( )

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE's CLAIM NUMBER
		– –	– –

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Office of Hearings and Appeals will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Check one of the blocks:

☐ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. (If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative).)

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

8. (CLAIMANT'S SIGNATURE) (DATE)	9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)
ADDRESS	(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY;
CITY STATE ZIP CODE –	CITY STATE ZIP CODE –
TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –	TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
☐ Initial Entitlement Case
☐ Disability Cessation Case
☐ Other Postentitlement Case

16. **HO COPY SENT TO**: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; or
☐ Title II CF held in FO to establish CAPS ORBIT; or
☐ CF requested ☐ Title II; ☐ Title XVI ☐ Title VIII
(Copy of teletype or phone report attached)

17. **CF COPY SENT TO:** _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI
☐ Other Attached: _____

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disablility-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ HI Entitlement	(HIE)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

Form **HA-501-U5** (5-2003) ef (05-2003)
Destroy Prior Editions

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

CLAIMANT

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(a) and (b), and 1869(b)(1) and (c), and Public Law 106-169 (Section 809(a)(1) of Sections 251(a)) as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to*: *SSA*, *1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Disability Programs

Form SSA-561-U2

Request for Hearing by Administrative Law Judge

If you do not agree with the reconsideration determination we made on your claim, you may file a request for hearing before an Administrative Law Judge (ALJ). To request a hearing, you may use this form or write a letter.

If you are not sure this is the form you should use, the Notice of Reconsideration (reconsideration determination) will tell you that to appeal our determination you should request a hearing before an ALJ. If the notice does not say this, or if you still are not sure this is the form you should complete, call 1-800-772-1213 or your local Social Security office and they will help you to complete the right appeal form.

If you are requesting a hearing on the denial of a claim for disability benefits, you must complete and sign additional forms. These forms are the HA-4486, Claimant's Statement When Request for Hearing is Filed and the Issue is Disability, and SSA-827, Authorization to Disclose Information to SSA. You should also complete an HA-4631, Claimant's Recent Medical Treatment, and an HA-4632, Claimant's Medications. If you have worked since you filed your application for disability benefits, complete an HA-4633, Claimant's Work Background.

You may also need to complete a form SSA-1696, Appointment of Representative, if you are appointing a representative. Your representative should also sign the SSA-1696 before you send it to us.

You must file your appeal within 60 days from the date you got the reconsideration determination. We assume you got the reconsideration determination within 5 days of the date shown on that notice unless you can show us you did not get it within the 5-day period.

Time to Submit New Evidence: You should submit any new evidence you want the ALJ to consider within 10 days of the date that you file this request. If you will not be able to submit the evidence within 10 days, you must ask the ALJ for an extension of time to submit evidence.

How to Obtain the Form

Below you will find Form in Portable Document Format (PDF). To print the PDF version, you will need the Adobe Acrobat reader software. If you do not already have this special software, see our page on downloading and printing PDF documents.

After you download the Adobe Acrobat Reader, come back to this page and download the PDF version of the HA-501:

Request for Hearing by Administrative Law Judge, Form HA-501

How to Complete the Form

1. NAME OF CLAIMANT: Enter your name or the name of the person on whose behalf you are filing the request for hearing.

2. NAME OF WAGE EARNER: If you receive or are applying for Social Security benefits on someone else's work record, enter that person's name.

3. SOCIAL SECURITY CLAIM NUMBER: The Social Security claim number depends on the type of claim you are appealing. If the appeal is on a claim for:

    - Social Security benefits on your work record, enter your Social Security number (SSN).
    - Social Security benefits on someone else's work record (that is, the wage earner in 2.), enter that person's SSN.
    - Social Security benefits on your work record and on the wage earner's work record, enter both SSNs.
    - Supplemental Security Income (SSI), enter your SSN. ·
    - Social Security benefits on the wage earner's work record and SSI, enter both SSNs.

4. SPOUSE'S CLAIM NUMBER: If you are appealing a reconsideration determination in an SSI or concurrent (SSI and Social Security) claim, enter the your spouse's SSN.

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE: Tell us why you disagree with the reconsideration determination. If you need additional space, you can attach a separate sheet of paper. Include your name and Social Security claim number on any additional pages, and on all correspondence, you send to us.

6. ADDITIONAL EVIDENCE: If you have additional evidence to submit, check this block and enter the name and address of the source. (For example, if you have additional evidence to submit from your treating doctor, you would enter his or her name and address.)

7. APPEARANCE AT THE HEARING: You must check one of the blocks in this item to tell us if you want to appear at a hearing. If you do not want to appear, you must also complete form HA-4608, Waiver of Your Right to Personal Appearance Before an Administrative Law Judge.

8. Signature: Sign and date the form and fill in your address and telephone number. If you are filing on behalf of a child or an incompetent adult, enter your relationship to the claimant (for example, parent or legal guardian).

9. Representative's Signature: If you have a representative he or she should sign and complete this section. Do not delay filing your request for hearing to get your representative's signature. If you do not have a representative and would like someone to represent you (for example, an attorney), your local Social Security office can provide you with a list of representatives for your area.

Do not complete anything below the line that says "TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION - ACKNOWLEDGEMENT OF REQUEST FOR HEARING." We will complete this part of the form when we receive it.

Send the Form

Where To Send The Form

Print the PDF HA-501 on 8 1/2 x 11 inch paper, complete and sign the form, and mail it to your local Social Security office. If you are not sure where your local office is located, try our Social Security Office Locator service or call1-800-772-1213.

SOCIAL SECURITY ADMINISTRATION/OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER – –	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER *(Complete ONLY in Supplemental Security Income Case)*

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

6. CLAIMANT'S SIGNATURE DATE	7. REPRESENTATIVE'S SIGNATURE ☐ ATTORNEY ☐ NON-ATTORNEY
PRINT NAME	PRINT NAME
ADDRESS	ADDRESS
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –	TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

10. If "No" checked: (1) attach claimant's explanation for delay; and
(2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one:
☐ Initial Entitlement
☐ Termination or other

APPEALS COUNCIL
OFFICE OF HEARINGS AND APPEALS, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

12. Check all claim types that apply:

☐ Retirement or survivors	(RSI)
☐ Disability-Worker	(DIWE)
☐ Disability-Widow(er)	(DIWW)
☐ Disability-Child	(DIWC)
☐ SSI Aged	(SSIA)
☐ SSI Blind	(SSIB)
☐ SSI Disability	(SSID)
☐ Health Insurance-Part A	(HIA)
☐ Health Insurance-Part B	(HIB)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

PAPERWORK/PRIVACY ACT NOTICE

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We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

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Social Security Forms

Form HA-520

Request for Review of Decision/ Order of Administrative Law Judge

If you do not agree with the decision or order an Administrative Law Judge (ALJ) made on your claim, you may ask the Appeals Council to review the ALJ's action. To do this, you may use this form or write a letter.

If you are not sure this is the form you should use, the notice you received will tell you that to appeal the ALJ's decision or order you must request Appeals Council review. If the notice does not say this, or you are still not sure this is the form you should complete, call 1-800-772-1213 or your local Social Security Office and they will help you to complete the right appeal form.

You must file your appeal within 60 days from the date you got the hearing decision or order. We assume that you got the hearing decision or order within 5 days of the date shown on the notice unless you can show us you did not get it within the 5-day period.

Time to Submit New Evidence: You should submit any new evidence you want the Appeals Council to consider with your request for review. If you need additional time to submit evidence, you must request it when you file your request for review.

How to Obtain the Form

Below you will find Form in Portable Document Format (PDF). To print the PDF version, you will need the Adobe Acrobat reader software. If you do not already have this special software, see our page on downloading and printing PDF documents.

After you download the Adobe Acrobat Reader, come back to this page and download the PDF version of the HA-520:

Request for Review of Decision/Order of Administrative Law Judge Form HA-520

How to Complete the Form

1. NAME OF CLAIMANT: Enter your name or the name of the person on whose behalf you are filing the request for review.
2. NAME OF WAGE EARNER: If you receive or are applying for Social Security benefits on someone else's work record, enter that person's name.

3. SOCIAL SECURITY CLAIM NUMBER: The Social Security claim number depends on the type of claim you are appealing. If you are appealing a claim for:
    - Social Security benefits on your work record, enter your Social Security number (SSN).
    - Social Security benefits on someone else's work record (that is, the wage earner in 2.), enter that person's SSN.
    - Social Security benefits on your work record and on the wage earner's work record, enter both SSNs.
    - Supplemental Security Income (SSI), enter your SSN.
    - Social Security benefits on the wage earner's work record and SSI, enter both SSNs.
4. SPOUSE'S CLAIM NUMBER: If you are appealing a hearing decision or order on an SSI or concurrent (SSI and Social Security) claim, enter your husband's or wife's SSN.
5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because: Tell us why you disagree with the hearing decision or order. If you need additional space, you can attach a separate sheet of paper. Include your name and the Social Security claim number on any additional pages, and on all correspondence, you send to us.
6. Signature: Sign and date the form and fill in your address and telephone number. If you are filing on behalf of a child or an incompetent adult, enter your relationship to the claimant (for example, parent or legal guardian).
7. Representative's Signature: If you have a representative he or she should sign and complete this section. Do not delay filing your request for review to get your representative's signature. If you do not have a representative and would like someone to represent you (for example, an attorney), your local Social Security office can provide you with a list of representatives for your area.

Do not complete anything below the line that says "THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART." We will complete this part of the form when we receive it.

Where To Send The Form

Send the Form

Print the PDF HA-520 on 8 1/2 x 11 inch paper and complete and sign the form. You may file this form (or your letter) with your local Social Security office. If you are not sure where your local office is located, try our Social Security Office Locator service or call 1-800-772-1213. You may also mail your request to the Appeals Council, Office of Hearings and Appeals, 5107 Leesburg Pike, Falls Church, VA 22041-3255.